ARIZONA DEPARTMENT OF HEALTH SERVICES, OFFICE FOR CHILDREN WIT H SPECIAL HEALTH CARE NEEDS
TBI/SCI/CYSHCN BILLING AND INVOICE PACKET
MONTHLY INVOICE
CONTRACTOR NAME: **ADHS PO#**
ADHS CONTRACT # **St ate Fiscal Year 2008**
BILLING MONTH: **Date:**

SERVICE DESCRIPTION	TBI/SCI					CYSHCN				Grand Total
	Approved Budget	TBI Amount Billed	SCI Amount Billed	TBI/ SCI Unexpended Amount	TBI/ SCI Cumulative Expenses	Approved Budget	CYSHCN Amount Billed	CYSHCN Unexpended Amount	CYSHCN Cumulative Expenses	
Family Resource Coordinat ion										
Community Outreach/Education										
Staff Training										
Mileage Reimbursement										
Direct Care Services										
TOTAL										

Contractor: _____ (authorized agent)	**DATE:** _____
ADHS Program Manager _____ (authorized agent)	**DATE:** _____

For ADHS Use Only			
PROGRAM	INDEX	PCA	TOTAL
TBI			
SCI			
CYSHCN			

Approved for payment:	Authorized Agent Signature:	Date